

Irving Orthopedics and Sports Medicine - Physical Therapy Department

Please print and complete all sections below.

PATIENT INFORMATION

Name :(Last) _____ (First) _____ M.I. _____
Address: _____ Home Phone: (_____) _____ - _____
City: _____ State: _____ Zip: _____ Work Phone: (_____) _____ - _____
Social Security # _____/_____/_____ Date of Birth: ____/____/____ Sex: M F
Emergency Contact: _____ Phone: (_____) _____ - _____
Relationship to patient: _____
Onset date for this episode / injury: _____
Have you had surgery for this episode/ injury? Y or N If yes, date of surgery: _____
Is this a work related injury? Y N Date of Injury: _____
Name of employer at time of injury: _____ Ph#: (_____) _____ - _____
Supervisor Name: _____ Ph#: (_____) _____ - _____
Occupation: _____

RESPONSIBLE PARTY INFORMATION

(if different from patient)

Responsible Party: _____ Date of birth: ____/____/____
Relationship to patient: ___Self ___Spouse ___Other: _____
Responsible Party's Address _____
City _____ State _____ Zip _____
Home Phone # (_____) _____ - _____ Work Phone # (_____) _____ - _____

PATIENT'S INSURANCE INFORMATION

PRIMARY Insurance Company's Name: _____
Name of Insured: _____ Date of Birth: ____/____/____
Relationship to insured: ___Self ___Spouse ___Child ___Other: _____
SECONDARY Insurance Company's Name: _____
Name of Insured: _____ Date of Birth: ____/____/____
Relationship to insured: ___Self ___Spouse ___Child ___Other: _____

CONTACT AUTHORIZATION

Please check where you can be reached during business hours: ___ Home ___ Work ___ Cell
May we contact you at home? ___ Yes ___ No May we contact you at work? ___ Yes ___ No
Leave message with: _____ Leave message with: _____
Voicemail / Answer Machine: Y / N Voicemail / Answer Machine: Y / N
Mobile Phone: Y / N Mobile Phone: Y / N
Family Member: Y / N Family Member: Y / N
May we contact you via email? ___ Yes ___ No Email address: _____

PLEASE SIGN AND DATE BELOW

Patient Signature: _____
Date: _____

FOR OFFICE USE ONLY

Referring Physician: _____ UPIN # _____
Dx: _____ Rx date: ____/____/____ Freq / Duration: _____
Appt. Date: ____/____/____ Appt. Time: _____ Intake completed by: _____ Date: ____/____/____ Provider _____